

# Group Information

Group Legal Name:

Group DBA Name:

Group NPI Number:

Fax Number:

Fax Number:

Fax Number:

Tax ID:

Specialty of Group:

Primary Service Address:

Phone Number:

Secondary Service Address:

Phone Number:

Billing Address:

Phone Number:

# Office Contact

Office Contact Name:

Office Contact

Phone:

Office Contact Email:

# 

# Provider(s) Information

Provider Name:

Provider NPI Number:

Social Security Number:

Date of Birth:

Primary Specialty:

Secondary Specialty:

Board Certified:

Name of Certifying Board:

Provider Type PCP \_\_\_\_ Specialist \_\_\_\_ Both \_\_\_\_



**Documents Required for Credentialing Purpose:**

* W-9 Form
* IRS Letter (CP 575)
* State License
* DEA Certificate
* CDS Certificate (If applicable)
* CLIA Certificate (if applicable)
* Residency Diploma
* ECFMG Certificate (If foreign graduate)
* Board Certification (If applicable)
* Professional Liability Insurance Certificate
* Hospital Affiliation
* Collaborative Agreement

|  |  |  |  |
| --- | --- | --- | --- |
| Portal Name | Username | Password | Associated E-mail |
| PECOS, NPPES, I & A |  |  |  |
| CAQH |  |  |  |



# Insurance Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sr# | Insurance Name: | Already Enrolled | Provider ID | Want To enroll |
| 01 |  |  |  |  |
| 02 |  |  |  |  |
| 03 |  |  |  |  |
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| 19 |  |  |  |  |
| 20 |  |  |  |  |

All information provided to MedICD is filled out to the best of your knowledge and completely accurate

Signature:

Print name:

Role in medical faculty/ Office: